Legislative Research Department July 24, 1975

M I N U T E S

SPECIAL COMMITTEE ON HEALTH AND HUMAN RESOURCES

June 20, 1975

Members Present

Representative Richard B. Walker, Chairman
Senator Elwaine F. Pomeroy, Vice-Chairman
Senator John F. Vermillion
Senator William Mulich
Representative J. Santford Duncan
Representative Anita Niles

Staff Present

Emalene Correll, Legislative Research Department
Myrta Anderson, Legislative Research Department
Alden Shields, Legislative Research Department
Norman Furse, Revisor of Statutes' Office

Others Present

Marvin Littlejohn, State Representative, Phillipsburg, Kansas
Mary J. Wiersma, Kansas Farm Bureau, Manhattan, Kansas
Jack Roberts, Blue Cross-Blue Shield, Topeka, Kansas
Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Gary Robbus, Kansas State Nurses' Association, Topeka, Kansas
Cinda Vogel, Kansas Chiropractors Association, Topeka, Kansas
Phil Patterson, U.S. Public Health Service, Region 7, Kansas City, Missouri
Dr. Holman Wherritt, U.S. Public Health Service, Region 7, Kansas City, Missouri
W. W. Marshall, U.S. Public Health Service, Region 7, Kansas City, Missouri
Nelson A. Tilden, Kansas Hospital Association, Topeka, Kansas
Frank L. Gentry, Kansas Hospital Association, Topeka, Kansas
Carl Schmittheuner, Jr., Kansas State Dental Association, Topeka, Kansas
Joe Harkins, State Department of Health and Environment, Topeka, Kansas
Dennis Hauver, State Department of Health and Environment, Topeka, Kansas
Dwight F. Metzler, State Department of Health and Environment, Topeka, Kansas
Eleanor Smith, League of Women Voters, Lawrence, Kansas
Raymond R. Solee, State Department of Health and Environment, Topeka, Kansas
Pauline Bork, student, Lawrence, Kansas

The meeting was called to order at 10:00 a.m. by the Chairman, Representative Walker, who called attention to the dates for Committee meetings asking that any requests for changes be given to him or a staff member before the end of the day. He then summarized Proposals No. 22 and No. 23 which had been assigned to the Committee.

Proposal No. 23 - Health Planning Programs and Health Care Facilities

Dr. Holman Wherritt, Director, United States Public Health Services Region 7 Office, introduced two members of his staff, Phil Patterson, liaison for Kansas; and Will Marshall, liaison for Missouri. Mr. Patterson specializes in implementation of the new federal act and Mr. Marshall in certification of need legislation.

In answer to a question, Dr. Wherritt stated that section 1122 is an optional program whereby states can elect to review all capital expenditures for health facilities on the basis of need for the facility and recommend whether or not the facility be allowed to participate in federal reimbursement programs such as Medicare and Medicaid.

Dr. Wherritt then presented background information on health planning and resource development dating back to World War II when the primary concern was facility planning. The recommendations of a Commission appointed by the President led to enactment of the Hill-Burton Act which provided federal grant funds for hospital construction and required a state plan for hospital development. The Hill-Burton Act placed emphasis on needs of the rural areas.

This was followed by a deluge of health legislation, including Medicare and Medicaid which provided health care purchasing power for certain groups of people to meet certain categories of health needs.

Recommendations of a President's commission led to legislation to increase the capacity for providers of health care to translate available technical knowledge into skills and services available to meet health needs primarily in the areas of heart, cancer and stroke. Emphasis of this program, known as the Regional Medical Program, was on the curative aspects of health needs.

The programs led to comprehensive health planning legislation which was divided into three major sections: (1) 314(a) which required establishment of a state agency to be responsible for developing a comprehensive health plan; (2) 314(b) which required establishing regional health planning agencies which were to place emphasis on planning for large urban and multi-county areas; (3) 314(c) which provided for training programs in institutions in each area to train planning personnel in the health area. There were also amendments to the Social Security Act.

According to Dr. Wherritt, other changes in health care were also taking place, such as the move away from the general practitioner to the specialist in medicine; development of a science of medicine rather than an art of medicine; division between the preventative, curative and rehabilitative aspects of medicine; and increased mobility of the population--all contributed to the fragmentation of medical care and services.

The need for pulling the fragments together and for developing a more effective form of delivery of health care led to an emphasis on comprehensive planning and what might be called administrative medicine.

The new Health Resources Development and Planning Act addresses itself to pulling together what now exists, to filling in gaps to provide delivery of health services to a specific population and to provide for continuity of care. This legislation which is divided into two parts, planning and facilities, replaces the Hill-Burton Act, the Regional Medical Program Act and the Comprehensive Health Planning Act.

Dr. Wherritt stated the Secretary of Health, Education and Welfare is responsible for issuing guidelines and regulations which are to be prepared after input from health agencies and institutions at other levels. It is difficult to be very specific in regard to requirements which must be met until these guidelines and regulations are available.

There will not be much activity until after August 1, 1975, the deadline for designating health service areas. All health systems agencies are to be formed and approved by June 1976. As a part of the transition to the new program, they will be approved conditionally for up to two years.

Governor Bennett has submitted a plan for Kansas recommending four health service areas and keeping metropolitan Kansas City as one area contingent on equal representation for Kansas. Since Area I, Western Kansas, did not meet the minimum population requirement under the federal act, the Governor's plan was submitted to a panel which recommended that the Governor's request for a waiver for this area be upheld.

It was pointed out by a Committee member that certain services stipulated by the federal law must be provided irrespective of the amount of federal money granted or the population encompassed.

Staff raised the question of the mechanics of designating a health systems agency since applications go directly to HEW. Dr. Wherritt replied that the mechanism will be similar to that used under 314(b). Any applicant will be required to get letters of endorsement. The regional office of HEW will be working with all applicants. In addition, all applicants must submit a copy of the application to the Governor's Office. Although there is no formal procedure for the Secretary of HEW to notify the state of all applications, he does plan to do so.

The Governor has recommended to the Secretary of HEW that the Department of Health and Environment be designated as the state agency under the federal act. This agency will develop a preliminary state plan which must include secondary and tertiary types of care not included in the HSA plans. Assisted by a council (SHCC), the state agency will develop a final state plan on which to base review and recommendations of regional plans. The SHCC will also review applications for formula grants and advise the state agency.

The SHCC is to be composed of at least 16 members appointed by the Governor: 60% chosen from HSA's, 40% designated by the Governor from outside HSA's; 50% are to be consumers.

The agencies, which must have a consumer majority, have the responsibility of developing a comprehensive plan to meet the needs of the maximum population of the area, placing emphasis on primary care. HSA's cannot subcontract or delegate their authority but sub-areas can be established with councils that are advisory only. Since the HSA cannot sub-contract with these councils it is assumed they cannot give them money. Sub-area councils must also have a consumer majority.

In answer to questions, regional office staff stated that area plans go to the federal agency, which reviews them for compliance with federal regulations, and to the state agency, which reviews the substantive part of the plan to see if it meets the needs of the population to be served. The state agency then develops a preliminary over-all state plan which is to be submitted to the SHCC. Although the function of the SHCC is to review and advise, it does have a great deal of authority in that it develops the final state plan which then becomes the basis for review and recommendations.

A question was raised as to whether the government may reach a point of telling professionals where they must serve. Dr. Wherritt stated it will be the responsibility of the community to get the professionals it needs with assistance from the state and federal government. A Public Health Service doctor could be assigned to an area as part of the plan. There has been legislation introduced which would provide that a medical school would receive federal money only if a student agrees to serve a certain community after graduation. Other federal legislation is also being considered which would influence the movement and flow of doctors.

Federal funding under the new federal act is to be on the basis of fifty cents per person. In addition, the state may contribute twenty-five cents to be matched at the federal level. There could be a total of seventy-five-cents-per-person federal money granted to the area. In answer to a staff question, Dr. Wherritt stated he thought the state matching money would have to be cash and would have to be "clean money".

Criteria relative to staff for HSA's is yet to be developed but there is a requirement of one staff person per 100,000 population served. This requirement refers only to professional staff.

The meeting was recessed for lunch.

The meeting was reconvened at 1:30 p.m. by the Chairman, Representative Walker.

Dr. Wherritt continued his presentation by stating that Title 16 replaces the Hill-Burton Act in terms of facilities construction and modernization with a reorientation of thrust to place emphasis on outpatient rather than inpatient care. Emphasis will also be on modernization of existing facilities rather than construction of new ones. Facility plans must be approved by the SHCC as to consistency with the state plan. Money will be available primarily through loans and loan guarantees although there will be limited grant funds under specified circumstances. Grants for medical facilities will probably come to the state on a formula basis with the requirement that a certain portion of the money be used in rural areas. There will be a different mechanism for loans and loan guarantees.

Regional staff pointed out that consideration will have to be given to whether or not the state agency has, under state law, the authority to perform its tasks. Certification of need legislation will have to be reviewed. A requirement for participation is that a state agency administers a certification of need program which satisfies HEW requirements. Currently in Kansas a certificate of need is approved by the area health planning agency and is issued by the state agency. Mr. Marshall pointed out that in one state the state agency consults with the local agency but final approval is given by the state agency. Under 1122 contracts certification of need must be determined by the state agency.

Another area to be considered is that in Kansas there is a Hospital Facilities Advisory Committee which must review plans for facilities. The new law stipulates this as a responsibility of the SHCC.

Consideration also needs to be given to developing an adequate appeal mechanism.

Regional staff pointed out that the next step is for them to work with the appropriate group to develop a list of things that will need attention. Sometime during the summer, guidelines, model certification of need legislation, and other model legislation should be available.

Questions were raised relative to the annual implementation plan and its relationship to the original plan. Dr. Wherritt pointed out that the first plan establishes long-range goals. The annual implementation plan relates to specific steps to be taken in that fiscal year to reach a specific long-range goal. No answer was given to a question relating to the means of enforcing compliance with the plans.

Dr. Wherritt stated that the federal law does stipulate state maintenance of effort. If a state provides money for the administration of the present Hill-Burton program, they may be able to include this in maintenance of efforts.

n answer to a question regarding the services developmental fund, regional staff stated this is a fund which could reach a maximum of $1.00 per person to be made available to the local agency to help them implement the annual implementation plan. It is to be a contract agreement and no matching funds are required.

Questions were raised relative to existing programs and the transition period. It was pointed out that a CHP could apply to become an HSA but it would have to prove that it would operate in a new way. Although the HSA's will be funded as of January 1, there is a provision for three additional months funding for the phasing out of the 314(a) and 314(c) programs. No additional funds will be available for 314(c) programs.

It was noted that the committee will be functioning for the interim period only and suggested that the regional staff establish lines of communication with the Research Department staff. The chairman asked for copies of model legislation and requested advance notice of any guidelines and regulations that might necessitate changes in existing laws or require additional state legislation. He suggested an additional joint meeting to go over model legislation and to discuss issues which might arise. Dr. Wherritt asked that the Committee notify Mr. Patterson of any requests. The Regional Office will try to meet them.

Chairman Walker thanked the Regional Office staff for their time and help.

Dwight F. Metzler, Secretary, State Department of Health and Environment, introduced two of his staff members; Joe Harkins, Director of Planning and Education and Raymond Solee, Director, Bureau of Health Planning.

Mr. Metzler reviewed what had been done by the Department to date. Two meetings were held with provider groups both of which recommended the whole state be designated as a single HSA. Public meetings were then held throughout the state. A summary of the new federal law and alternatives for the area boundaries were presented. Personnel from the Regional Medical Program made a formal presentation at each of these meetings. Results of a poll taken by ballot at each meeting indicated people wanted the areas kept as small as possible to maximize local input. What was recommended by the Governor was a compromise between the two most popular alternatives.

Mr. Metzler stated that HEW will start reviewing the applications for areas in September with all HSA's to be approved by the end of December. The Department is involving the existing area-wide councils in the development of HSA's. There is a problem in Region IV, but steps are being taken to resolve it.

Mr. Metzler pointed out that one area of concern is that if a private corporation is created it is responsible to no one at the state level. The corporation would be responsible only to HEW and could be dominated by groups that did not have as their first interest good health care for Kansans. One way to avoid this situation would be for the membership to be selected by officials of the Regional Medical Program. If there is dissatisfaction, the people who made the selection or who may be members themselves (RMP officials could select themselves) could be voted out of office. He asked the Committee to give this proposal consideration.

The State Department of Health and Environment expects to be appointed as the state agency. (Attachment A) They do not plan to duplicate planning done at the HSA level but will draft a tentative state plan and will do enough planning to review plans submitted by HSA's to determine if they fit in with the state plan and include preventative as well as curative health care. State planning will serve as a yardstick to measure the quality of plans submitted to the state.

In answer to a question, Mr. Metzler stated that the state's primary source of enforcement power may be publicity. However, the Department plans to work on the positive side and use publicity only if a situation needs exposing. He expressed the feeling that the potential for conflict, especially during the transition period, is high. The Department plans to be very open in the development of the state plan and the review of plans submitted by the HSA's.

Mr. Solee presented areas in which the Department feels state legislation will be needed. (See Attachment B)

Mr. Harkins asked to speak to Proposal No. 22, stating he wished to point out that the problem of regionalization is very complex and needs a considerable amount of study before a good design can be developed. In view of his decision, they will be asking that the planning system created in Kansas under the new federal legislation give first priority to planning for regionalization and that such planning be a part of area plans submitted during the first year. From these plans, the state agency would develop a first draft for regionalization which could then be brought to the legislature with recommendations for implementation. In view of this, Mr. Harkins requested that the Committee postpone any definitive action on regionalization for one year.

The Committee questioned whether the state agency has any authority to require the area planning groups to comply with this request. If the HSA's do not comply, the state agency can still develop a plan within the same time period. Mr. Metzler stated he is willing to commit the Department to having a first draft by the next (1977) Session of the Legislature.

It was pointed out that although regionalization of health services can be defined as broadly or as narrowly as one wishes, the Department of Health and Environment is defining it as regionalization of public health programs with the first thrust to be in the area of prevention. This could then be followed by regionalization in other areas such as hospitals and individual services. The Department views public health programs as essentially prevention programs.

Mr. Metzler stated that although they may later request some authority not now in the law, he believes that the present law does give them the authority to implement the new federal legislation. This will be somewhat dependent on the regulations adopted.

Questions were raised relative to the viewpoint of the State Comprehensive Health Planning Council on the new federal legislation. It was noted by staff that Thad Sandstrom, Chairman of this Council, had been invited to appear before the Committee. However, he had to be in Washington and declined to send anyone in his place.

Instructions to Staff
Agenda for Next Meeting

Staff was asked to secure copies of the following for Committee members: (1) memorandum published by the State Board of Education delineating education services and health services; (2) summary done by Department of Health and Environment of the meetings they held throughout the state relative to the new federal legislation.

After discussion, the major consensus was that the phrase "review of local health statutes" in Proposal No. 22 referred to state statutes pertaining to the local level. It was suggested these be reviewed at the next meeting.

It was pointed out that the Committee needs to keep in mind that their task is to include looking at environmental services as well as health services.

Although consideration of recommendations regarding certification of need legislation will need to wait until federal guidelines are available, it was felt that some areas of policy could be isolated for consideration. Staff was asked to see if they could do this.

After discussion of the need for the Committee to hear from the local level, staff was instructed to write each local health officer and local Board of Health offering them the opportunity to appear to comment on funding, minimum services, various ways of providing minimum level of services including cooperative agreements, and the relationship between their local level and the State Department of Health and Environment.

The following tentative agenda was agreed to for the next meeting:

Proposal No. 22

Review of local health statutes - Staff

Comments from Health Officers and Boards of Health at the local level

Review of area meetings relative to the new federal legislation - Mr. Metzler

Prevention as a cornerstone of comprehensive health planning - Mr. Metzler

The agenda for the second day is to be left flexible enough to allow for the possible number of health officers and Board of Health members who may request to appear and to allow for Committee discussion.

The meeting was adjourned at 4:00 p.m.

Prepared by Emalene Correll

Approved by Committee on:

9/25/75
DATE

Attachment file A
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STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka

ROBERT F. BENNETT
Governor

May 27, 1975

Dwight Metzler, Secretary
Kansas Department of Health
and Environment
Topeka, Kansas 66620

Dear Mr. Secretary:

This letter is to express intention to designate the Department of Health and Environment, at the appropriate time, as the State Health Planning and Resources Development Agency. I will be proposing the designation of the Department of Health and Environment in light of its long history in planning and resources development.

The Department has been the state's Hill-Burton agency since the program's inception in the late 40's, and has been the state Comprehensive Health Planning Agency under Section 314(a) since 1967. Your department provided me with the staff support to develop my recommendations for health service area designations and I am confident you and your staff can provide the needed administrative leadership for the State Health Planning and Resource Development Agency.

Very sincerely,

Robert F. Bennett
Governor

RFB:jm

Attachment B

Kansas Statutes That Must Be Changed to Accomodate the Provisions of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641)

The present Kansas Certificate of Need Law for health or medical facilities licensed under laws of Kansas. (K.S.A. 65-2a01 et. seq.) will have to be amended to bring it into conformance with Section 1122 of the Social Security Act (42 USC 1320a-1) as added by Secion 221(a) of the Social Security Amendments of 1972 (86 Statute 1386-89) entitiled "Limitation on Federal Participation for Capital Expenditures." It is anticipated that 1122 will be the basis for the Federal Model Certificate of Need Legislation, identified in P.L. 93-641.

References herein to 1122 refer to HEW rules and regulations found in Volume 38 Number 218, Part II of the Federal Register, November 13, 1973. There are three areas of the Kansas Certificate of Need Law that must be amended to conform to 1122 requirements. One of these areas relates to the "entry amount" of capital expenditures by which projects of construction or improvement are brought within the purview of the law.

The present Kansas statute calls for an entry amount of $350,000 or 5% of the facility's operational budget of the previous year. 1122 provisions set the entry amount at $100,000 spent on change of bed capacity or services provided. Thus, the Kansas statutes will need to be changed to conform to the $100,000 entry amount. (K.S.A. 65-2a05) [1122 § 100.103(a)(1)(i)].

A second area where amendments to the Kansas statutes will be needed addresses the appeal process from designated planning agency decisions. The areawide councils presently have the responsibility for deciding whether a certificate of need will be issued or not in Kansas. The applicant, or other affected parties in the same geographic area may appeal the areawide councils' decision. Presently, K.S.A. 2a04 et. seq. states that all appeals will be dealt with through an administrative hearing before an appeal panel.

1122 provisions [§ 100.106(c)] states that a hearing officer may hear the appeal and make a decision. The appeal panel procedure will therefore need to be changed to an administrative hearing before a hearing officer.

1122 [§ 100.108(d)] provides that any person dissatisfied with a decision may within six months request the Secretary, U.S. Department of Health, Education and Welfare to reconsider.

The third major area where Kansas law conflicts with 1122 provisions deals with who has the authority to make decisions concerning approval or denial of Certificate of Need. Present Kansas Law [K.S.A. 65-2a02(d)] states that the areawide councils will have the responsibility of making decisions about the issuance of certificate of need.

1122 (§ 100.106) states that the state level designated planning agency will have the decision making responsibility in the area of health facilities construction or expansion. Therefore, the Kansas appeal panel concept will need to be changed to conform to the hearing officer's requirements.

Submitted by Solee for Department of Health and Environment

Kansas Law K.S.A. 65-190 et. seq. concerning the organizations and agencies involved in the present Kansas comprehensive health planning structure and the Kansas Hospital and Medical Facilities Survey and Construction Act (K.S.A. 65-410 et. seq.) will need to be amended to reflect the changed structure under P.L. 93-641. This will eliminate the need for the "State Health Planning Council" created by Section 65-192 and the "Advisory Hospital Council" created by Section 65-434 of the Kansas General Statutes of 1949 and amendments thereto.

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The following sections of the existing Kansas Statutes Annotated may need to be either amended or deleted to accomplish alignment with the reorganization necessitated by the implementation of P.L. 93-641. Further refinement of this list will be part of our program in the regulation area.

State Health Planning (Comprehensive Health Planning)

1. 65-190 Comprehensive state health planning

2. 65-191 Funds for health planning, administration by board of health

3. 65-192 State health planning council

4. 65-194 Rules and regulations for state health planning

5. 65-195 Expenses of members of state health planning council

6. 65-196 Cooperation of agencies and officers

7. 65-2a01 Definitions

8. 65-2a02 Planning agencies, membership of board of directors; activities and duties of agencies; approval or disapproval of program requests; appeals; certificate of need, issuance and filing

9. 65-2a03 Approval or disapproval of program requests; time limit, extension; notice of approval or disapproval of program requests

10. 65-2a04 Planning regions, numbering; appointment of representatives to appeals panels

11. 65-2a05 Programs costing in excess of 5% of operating cost of preceding year or $350,000 required to be approved

12. 65-2a06 Prelicensing request for certificate of need; information required

13. 65-2a07 Appeals

14. 65-2a08 Action permitted in determination of request or appeal; approval or disapproval final;when; termination of approval; appeals to district court; notice and approval.

15. 65-2a09 Applications for original license or program in excess of limitations of 65-2a05 to include certificate of need; certificate of need forms, preparation distribution

16. 65-2a10 Assets destroyed by catastrophic or natural disaster; replacement without approval

17. 65-2a11 Application of act to existing projects

18. 65-2a12 Application of act to existing project proposals

19. 65-2a13 Application of act to state or federal facilities

20. 65-2a14 Severability

Hospital and Other Facilities Survey and Contraction Acts

21. 65-411 Definition

22. 65-412 Administration

23. 65-413 General powers and duties

24. 65-414 Advisory hospital council; compensation and expenses; meetings

25. 65-415 Survey and planning activities

26. 65-417 Application for federal funds for survey and planning; expenditure

27. 65-418 State plan for construction program and administration; hearing; publication upon approval; modification of plan

28. 65-420 Construction projects; applications

29. 65-421 Consideration and forwarding of applications

30. 65-422 Inspection of projects; certification

31. 65-423 Hospital and medical facilities construction fund; deposit of federal moneys; uses

PROPOSED TRANSITION PLAN FROM AREAWIDE COMPREHENSIVE HEALTH PLANNING AGENCIES TO HEALTH SYSTEMS AGENCIES IN KANSAS

I. Health Systems Agency Requirements

A. Legal Structure

1. A non-profit private corporation, or

2. A public regional planning body, such as a Council of Governments, or

3. A single unit of general local government

B. Staff

1. Expertise

a. administration

b. gathering & analyzing of data

c. health planning

d. development of & use of health resources

2. Size and Employment

a. not less than 5 but as high as 25 based on quotient of population ÷ 100,000

b. selection, salary, promotion, and discharge based on policies established by agency

c. pay rate shall not be less than the rate of pay prevailing in the HSA

C. Governing Body

1. Not less than 10 or more than 30 members

2. Responsibility

a. internal affairs

1. Staff

2. Budget

3. Procedures & Criteria

b. establishment of Health Systems Plan (HSP) and Annual Implementation Plan (AIP)

c. approval of grants & contracts made and entered into

d. approval of all review activity

e. an annual report

f. reimbursing its members for their reasonable cost incurred in attending meetings of the governing body

g. meet six times per year at minimum unless an executive committee meets then minimum of 4 meetings per year for full governing body

h. conduct meetings in public with adequate notice to the public of the meeting

i. not less than one-half of governing body or of executive committee needed for a quorum

3. Composition

a. majority (not to exceed 60%) shall be consumer residents of the HSA (and have not been providers of health within the 12 months preceding appointment)

b. not less than 1/3 shall be direct providers of health care

1. Physicians, dentists, nurses and other health professionals

2. Health care institutions

3. Health care insurers

4. Health professional schools

5. Allied health professionals

c. shall include:

1. Elected officials and other representatives of governmental authorities in the HSA

2. Representatives of public and private agencies in the HSA concerned with health

3. Equal % of nonmetropolitan members to % of residents in nonmetropolitan areas

4. VA ex-officio member if one or more VA hospital or other health facility in HSA

5. At least one representative of HMO if one or more HMO is located in the HSA

d. subcommittees of its members or an advisory group, to the extent practicable, shall have appointees providing the same representation of the governing body

4. Individual liability - waived unless a member acts with malice.

5. Private contributions - no HSA may accept any funds or contribution of services or facilities from any individual or private concern that has some direct interest in the development, expansion, or support of health resources, unless the concern is an organization described in Section 509 (a) of Internal Revenue Code of 1954 and not a provider of health care in the HSA.

6. Subarea councils

a. May be formed as advisory with like composition to governing body.

D. Primary Responsibility of HSA

1. The primary responsibility of the health systems agency is effective health planning and development of health services, manpower and facilities in its area.

E. Functions of HSA

1. Assemble & analyze data

2. Establish, annually review and amend an HSP

3. Establish, annually review and amend as necessary an AIP

4. Provide technical assistance for development of projects in accordance with the priorities established in the AIP

5. Make grants to public & nonprofit private entities and enter into contracts to develop projects and programs in accordance with HSP. Such grants or contracts shall be made from the Area Health Services Development Fund.

6. Review and approve or disapprove proposed use of federal funds in HSA (except grants or contracts under title IV, VII, or VIII under special circumstances and federal funds proposed for federally recognized Indian reservation the HSA may only review and comment)

   a. Secretary to allow 60 days for such review

7. Provide Indian tribes or inter-tribal organizations information regarding the availability of federal funds.

8. Assist the state health planning agency in 1122 and certificate of need reviews

9. Periodically review and make recommendations to the state health planning and development agency of all institutional health services offered in the HSA as to the appropriateness of such services in the area. The first review to be completed in three years.

10. Annually recommend to the state health planning and development agency the HSA's

    a. projects for modernization, construction, and conversion of medical facilities which projects will achieve the HSP and AIP

    b. priorities among such projects

F. Funding Authorization

1. For planning

   a. federal funds equivalent to $0.50 per capita or $3,750,000, whichever is less

   b. federal funds up to $0.25 per capita to match equally any non-federal funds to be obligated by the HSA

2. for resource development

a. federal funds not to exceed $1.00 per capita.

II. Suggested State Guidelines for Transition

A. That existing areawide CHP organizations be encouraged to form Health Systems Agencies on a regional basis by formal mergers. (See attached chart.)

B. That appropriate planning organizations be invited to participate in planning and execution of the proposed mergers of areawide health planning councils to assure future coordination between health planning and other regional planning.

C. That leadership and participation in development and governance of Health Systems Agencies be kept at the local and regional level to the maximum extent possible.

D. That appropriate technical assistance in the preparation of Health Systems Agency applications and agency development be deferred until a consensus is reached at the regional level regarding the development of an appropriate applicant (evolved from the proposed merger of areawide Health Planning Councils).

E. That the State Department of Health and Environment coordinate technical assistance to HSA applicants. Assistance may be requested from such organizations as KRMP; various state agencies; various professional organizations such as KHA, KMS, etc.

III. Advantages

A. Maximize the participation of persons (providers, consumers, elected officials) that have gained several years of health planning experience in areawide Health Planning Councils.

B. Provide maximum coordination between regional planning agencies (HSA's and RPC's).

C. Build HSA's with a maximum of local participation.

D. Avoid totally unnecessary efforts to start planning and development activities from scratch which may not use present capabilities and could precipitate confusion and unproductive competition.

E. Provides an opportunity for consumers with knowledge and experience in health planning to participate.

F. Builds on previous planning experiences and assures continuity of local program development.

IV. Summary

A. This is a proposal to:

1. Merge existing areawide Health Planning Councils into regional health planning agencies (HSA's) which would then be funded and staffed with federal financed support.

2. Form a joint venture of existing Regional Planning Commissions to provide continuity for the new HSA's and assure maximum coordination between health planning and all related regional planning efforts.

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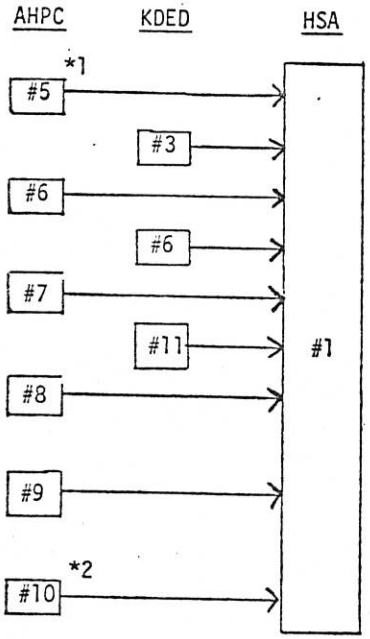
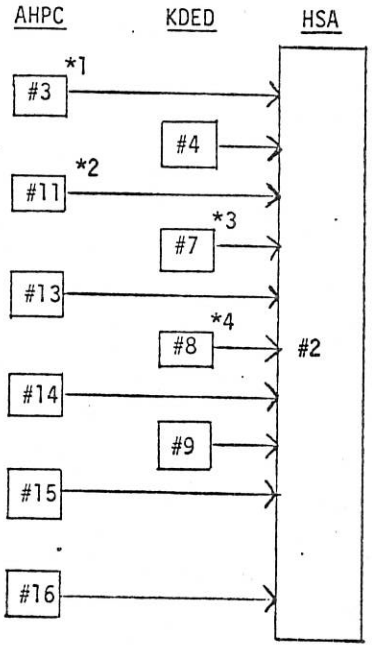
5-30-75

Consolidation of Areawide Health Planning Councils (as identified by the Bureau of Comprehensive Health Planning, February 14, 1975) and Kansas Department of Economic Development Regions (as identified in Kansas Planning for Development Report #60, August, 1974) in order to apply for Health Systems Agency Designation.



*1 AHPC #5 minus Harper, Reno and Rice counties.

*2 AHPC #10 minus Dickinson county.

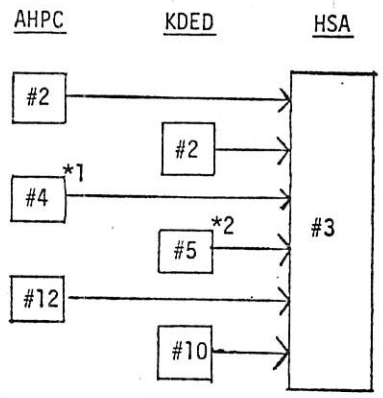


*1 AHPC #3 minus Greenwood county.

*2 AHPC #11 plus Dickinson county from AHPC #10.

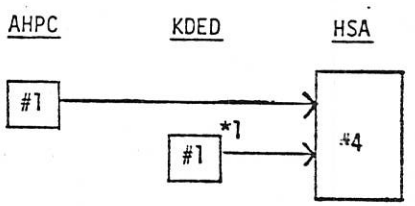
*3 KDED #7 minus Anderson, Linn and Johnson counties.

*4 KDED #8 minus Marion county.



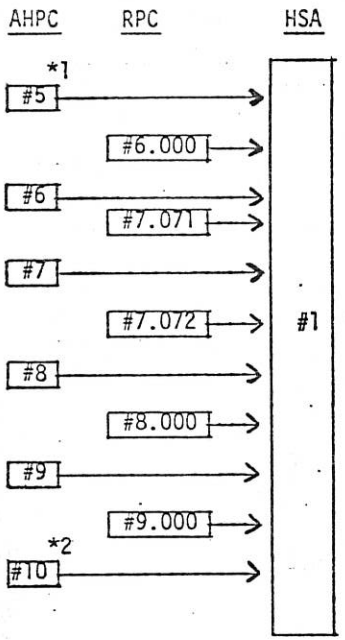
*1 AHPC #4 plus Greenwood county from AHPC #3 and plus Harper, Reno and Rice counties from AHPC #5.

*2 KDED #5 plus Anderson and Linn counties from KDED #7.



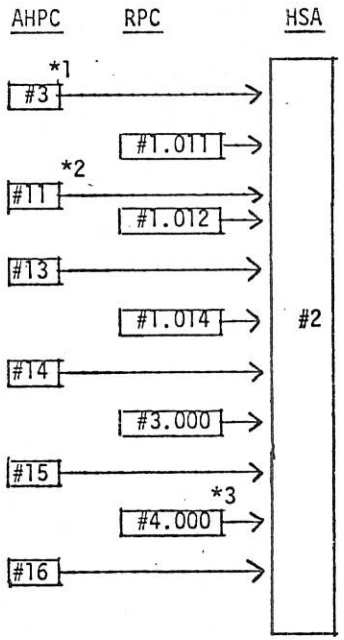
*1 KDED #1 plus Johson county from KDED #7.

Consolidation of Areawide Health Planning Councils (as identified by the Bureau of Comprehensive Health Planning, February 14, 1975) and Regional Planning Commissions (as identified by the Department of Planning and Research, March 25, 1975) in order to apply for Health Systems Agency Designation.



*1 AHPC #5 minus Harper Reno and Rice counties.

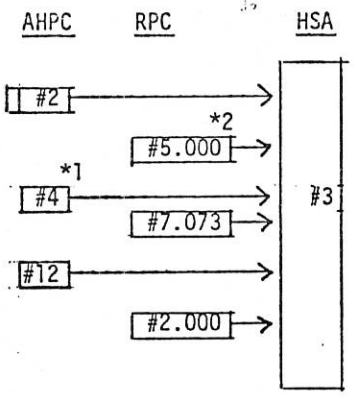
*2 AHPC #10 minus Dickinson county.



*1 AHPC #3 minus Greenwood county.

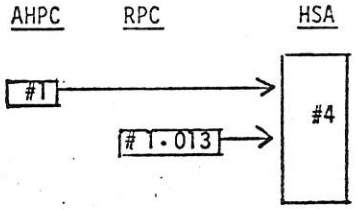
*2 AHPC #11 plus Dickinson county.

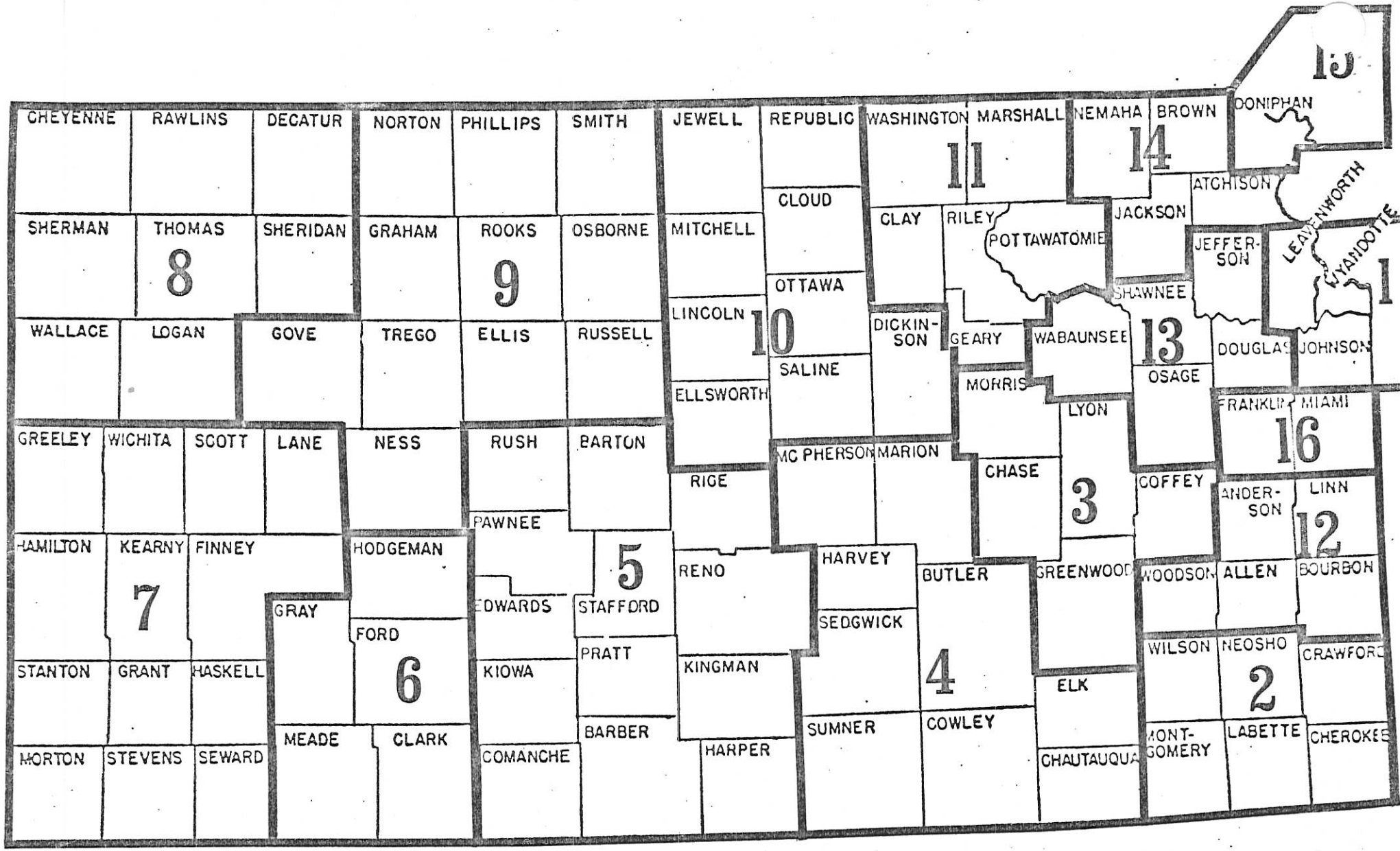
*3 RPC #4 minus Marion county.



*1 AHPC #4 plus Harper, Reno, Rice and Greenwood counties.

*2 RPC #5 plus Marion county.

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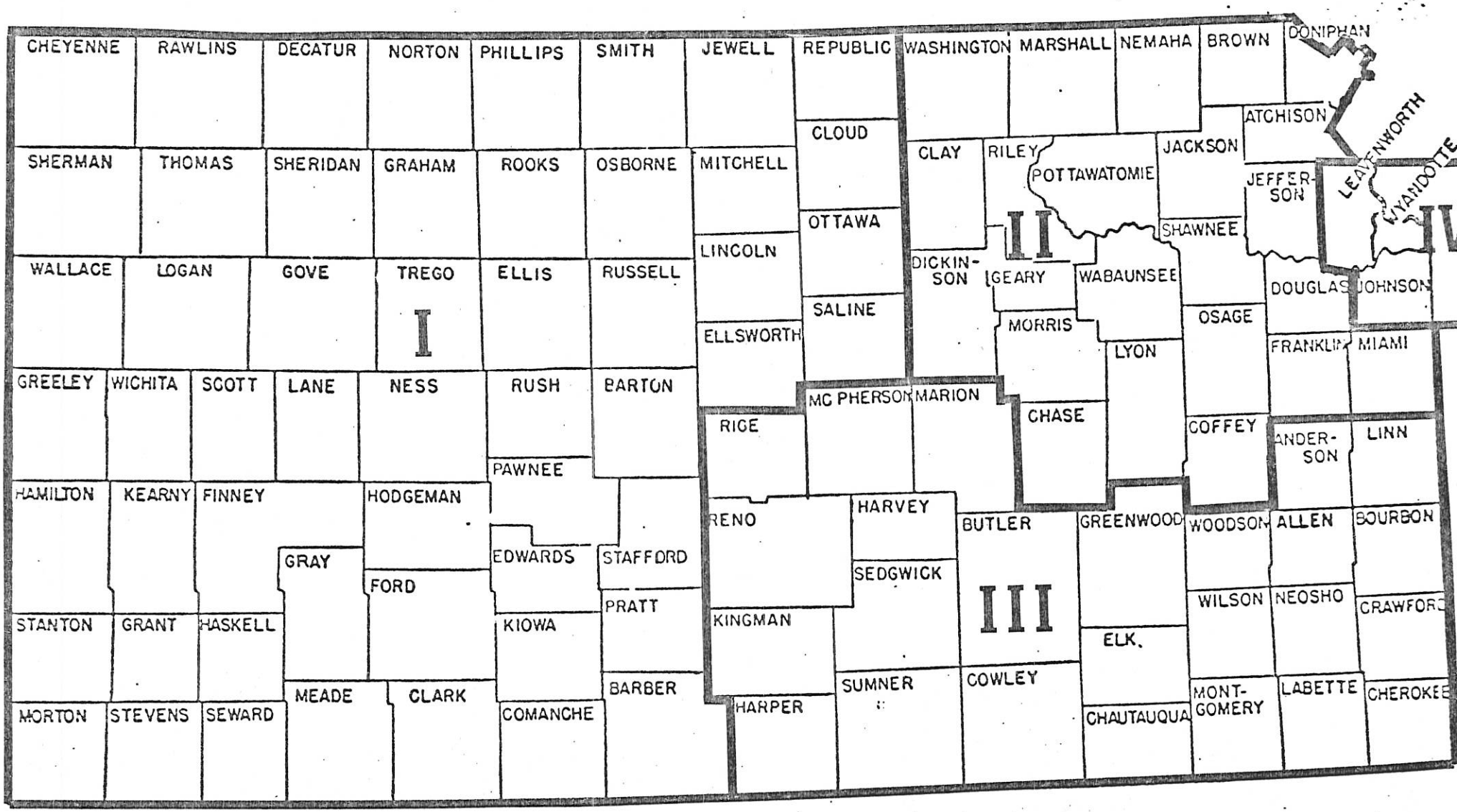
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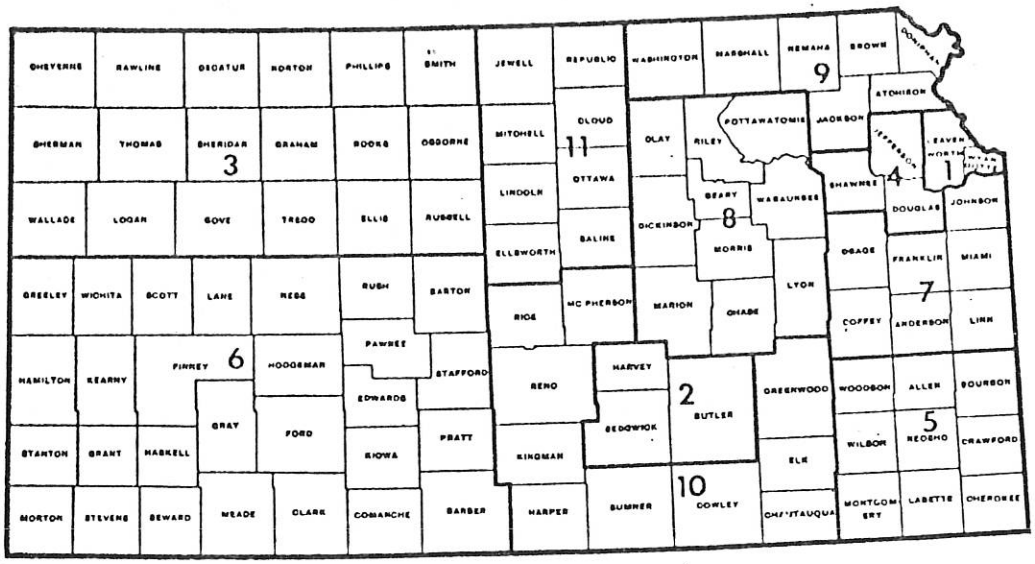
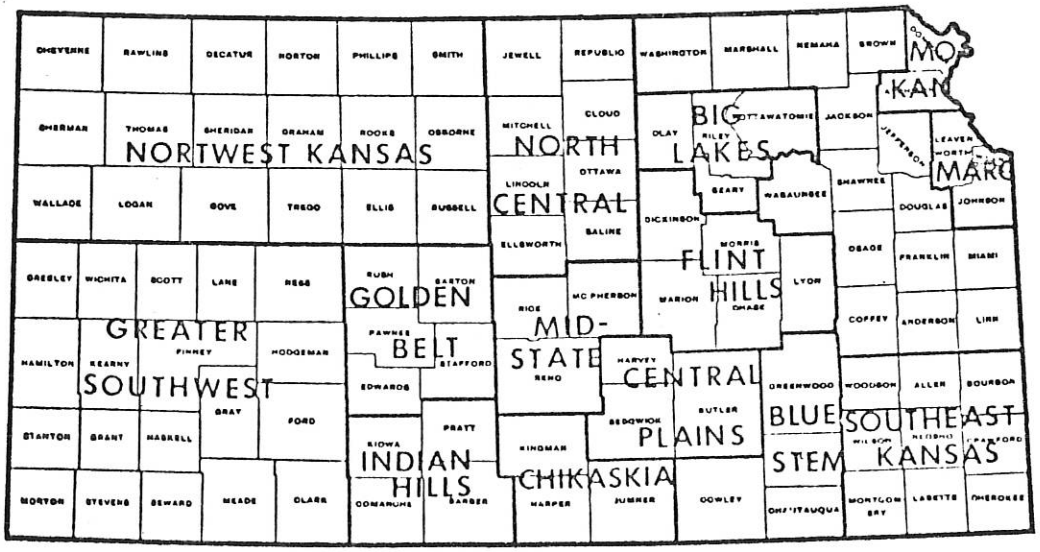


REGIONALISM AND REGIONAL PLANNING IN KANSAS



Kansas Planning for Development Report No. 60

STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka

ROBERT F. BENNETT
Governor

May 1, 1975

Mr. Caspar Weinberger, Secretary
Department of Health, Education and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

Enclosed herewith is my recommendation for designation of health service areas in the state of Kansas. I am proposing the designation of three service areas within the state, and a fourth which would include three Kansas counties in a bi-state area covering metropolitan Kansas City.

I am recommending multiple planning areas for the following reasons:

1. A majority of local health professionals, consumers, and elected officials favor this concept;

2. Decentralization will facilitate local consumer participation in the planning process;

3. Decentralization will create an opportunity for existing health planning agencies to apply for designation as health systems agencies;

4. Decentralization will facilitate coordination of health planning with established organizations such as medical societies and regional planning agencies.

The process of determining the exact boundaries for the recommended areas included examination and a synthesis of the following factors:

1. Present regional planning areas;
2. Economic trade areas;
3. Existing SMSA's;
4. Funded CHP areas;
5. Local and regional medical society boundaries;
6. Existing regional public health offices;
7. Federal population guidelines; and
8. Comments from existing CHP agencies, health professional groups, consumers, and elected officials.

My recommendation for bi-state planning in the Kansas City area is based upon three primary factors:

1. It is reflective of existing consumer patterns in the area and will, therefore, facilitate planning for the future;
2. Health planning can be better coordinated with other planning efforts being carried out on a regional basis;
3. Health planning is presently being carried out in the area on a cooperative basis with equal representation between Kansans and Missourians.

In making this recommendation for bi-state planning, I want to underline and emphasize that it is based and, for that matter, conditioned, upon the concept that the governing body of the health systems agency involved will be organized on the concept of equal representation for both Kansas and Missouri. As a matter of fact, I had originally intended to recommend that all health systems agencies be located entirely within the state of Kansas, feeling that that was the only way in which the sovereignty of this state, already badly eroded, could be preserved.

A number of citizens, providers and advisers feel, and wisely so, that if some assurance of cooperation and equal representation could be obtained, that a bi-state planning effort would have substantial advantage.

Based upon their urging and recommendations, the regional office of the Department of Health, Education and Welfare was contacted and advised representatives of my office that such an arrangement for equal representation was permitted by law and, in their view, would be looked upon with favor by their office. Contact has been made with Governor Bond of Missouri, and he has assured me that his office firmly believes that the best development of health planning for the Kansas City SMSA would be achieved by a bi-state program, and that he concurs with my strong recommendation for equal representation from both Kansas and Missouri. He has further indicated that he will provide every assistance possible to encourage that equal representation.

The local officials in the eight counties constituting the metropolitan area have delivered to me a copy of the resolution adopted by Mid-American Regional Council. Among other things, the formal resolution stated:

"The governing body for health planning of the Health Systems Agency shall:

(a) Contain equal voting membership from both the Missouri and Kansas portions of the health service area

(b) Be appointed and serve at the pleasure of elected officials."

Armed with these assurances and conditioned upon the fulfillment of the concept of equal representation for two sovereign states, I have made the recommendation aforesaid. I earnestly and most sincerely solicit and urge your full cooperation, and that of the Department of Health, Education and Welfare, to carry out the concensus of equal representation which has not been developed. Unless ultimately this concept can be implemented by the designation of a Health Systems Agency that has equal representation for each of these states, I would be subordinating the sovereignty of this state which I can not, and will not, do.

My concern in this matter does not relate solely to the argument of state sovereignty which, to me, may be more one of philosophy than of practicality. In this particular case, the Kansas portion of the Kansas City SMSA constitutes the academic health center for the state of Kansas. Practically every health profession in Kansas looks to the state's only medical school for continuing education and consultation. The Kansas Legislature has appropriated the sum of $63.6 million for the operation of this school, of which $21.9 million was appropriated from the state general fund for its support. The possibility, though remote, that the state's authority over this medical school and hospital might be in any way diminished or diluted, mandates that it be protected against such an eventuality. That protection can occur if the governing body of the bi-state health systems agency has equal representation for both Kansas and Missouri.

Mr. Secretary, I have attempted to carefully and fully explore the alternatives granted to me under the law, both federal and state, and to arrive at some workable concensus on the important issue of bi-state health planning in the Kansas City metropolitan area. While the concensus has been developed, it will certainly require the cooperation of the Department of Health, Education and Welfare to assure that the value of this cooperative and harmonious approach is neither obliterated or diluted by the guideline writing process.

Though not suggested by way of threat, but more by way of information, and to share with you the importance of the conditions of this recommendation, I would be less than frank if I did not state that should a health system agency application be ultimately approved which does not provide for equal voting representation between these two states, it would be my avowed intention to apply for, and exert every effort towards, a division of the bi-state area, and a designation of Leavenworth, Wyandotte and Johnson counties as a Kansas health service area.

I trust that you can see the importance of this matter and, under the concept of the "new federalism" you will exert your efforts towards the implementation of these recommendations with the essential characteristic for the bi-state area of equal representation.

Very sincerely,

RFB:m

Robert F. Bennett
Governor